₩.	Facet Injection Stud Case Report Form (C	,	
FACET INJECTION STUDY	Participant Initials:	Site ID:	Participant Trial ID:

CASE REPORT FORM

Facet-joint injections for people with persistent non-specific low back pain study (FIS)

Sponsor:	University of Warwick and University Hospitals Coventry and Warwickshire NHS Trust
EudraCT number:	2014-000682-50

PLEASE COMPLETE ALL CRF PAGES LEGIBLY USING A BLACK BALL-POINT PEN AND BLOCK LETTERS

**/	Facet Injection Stud Case Report Form (C				
FACET INJECTION STUDY	Participant Initials:	Site ID:	P	articipant Trial	ID:
VISIT A - Eligibility / D	Piagnostic Assessm	ient			
1. Date informed cons	ent signed by particip	pant :			
2. Under which version					
Full-time employed		pieuse tiek one	:/·		
Part-time employed					
	1				
Self employed					
Retired/looking afte	er home/inactive				
Unpaid work					
Unemployed					
Full time student					
Other, please specif	fy				_

FACET INJECTION STUDY		Facet Injection Study Case Report Form (CRF)				
	Participant Initials:	Site ID:		Participant Trial ID:		
VISIT A - Eligibility / D	iagnostic Assessm	nent				
INCLUSION CRITERIA						

Please tick all appropriate boxes. A response of NO disqualifies the patient from participation in the study.

		Yes	No
1.	Patient is able and willing to comply with the trial procedures and signed and dated informed consent is obtained.		
2.	Patient aged \geq 18 with at least moderately troublesome low back pain present for at least 6 months.		
3.	Patient's low back pain is their predominant musculoskeletal pain.		
4.	Patient has undergone registered health professional therapist-delivered treatment for low back pain in the preceding two years prior to inclusion.		
5.	Patient meets clinical criteria for possible facet joint pain .*		
6.	Patient is able to manage text messaging, or paper based diary for daily data collection.		
7.	Patient is fluent in written and spoken English.		

^{*}Where there is no radicular symptoms (defined as pain radiating below the knee) and no sacro-iliac joint pain elicited using a pain provocation test and increased pain unilaterally, bilaterally on lumbar para-spinal palpation, and increased low back pain on one or more of the following; extension (more than flexion), rotation, extension/side flexion, extension/rotation.

	\$\tag{\pi}	Facet Injection Study Case Report Form (CRF)												
;	FACET INJECTION STUDY	Participant Initials: Site ID	:	Partic	ipant Trial ID:									
•	VISIT A - Eligibility / Diagnostic Assessment													
	EXCLUSION CRITERIA													
PI	ease tick all appropriate bo	xes. A tick in a shaded box disqu	alifies the patie	ent from the stu		. No								
1.	Patient is able to attend fin the trial by an investiga	or randomised treatment and/ or	is considered u	nsuitable to par	ticipate									
2.	Patient is able and willing													
3.	Patient has used oral cort	icosteroids or had a corticosteroi	l injection in th	e past three mo	nths.									
4.	Patient has an underlying	serious psychiatric or psychologic	al disorder.											
5.	Patient has previously un	dergone spinal injections.												
6.	Patient has previously un	dergone spinal surgery.												
7.	Patient has a known cont	aindication* to facet joint injection	ons.											
8.	Patient has a known aller	gy to the constituents of the plan	ned injections.											
9.	Patient is pregnant, or su	pected pregnancy.												
10.	Patient was previously ra	ndomised in this trial.												
11.		pating in another clinical trial (wi lays have passed since completin	_											
*For example, a serious co-morbidity (e.g. severe chronic onset pulmonary disease (COPD), poorly controlled dia- betes) malignancy, infection, inflammatory disorder, or fracture or is taking anti-coagulants medications.														
	nclusion/Exclusion c	iteria review												
C	oes the patient continu	to meet all inclusion/exclusion	n criteria ?											
	Yes													
	No - Patient is wit	drawn from the study. Please co	mplete withdra	wal CRF page an	d Final CRF pa	ge.								
Pł	ysiotherapist/investigator	undertaking eligibility/diagnosti	assessment:											
Na	ame :													
Sis	nature :			Date signed:	DD - MON-YY	/yv								

第	Facet Injection S Case Report Form	· I
FACET INJECTION STUDY	Participant Initials	s: Site ID: Participant Trial ID:
VISIT A - Eligibility / I	Diagnostic Asses	ssment
MEDICAL HISTORY—E	Back pain and ge	eneral health
How long has the partic	ipant had back pa	in:
6 to 12 months	1 to 2 years	s 2 to 5 years >5 years
2. Previous back pain treat	ments: (tick all the	at apply)
Treatment type	Yes or No	If yes, enter date of last treatment or tick unknown
Physiotherapy	Yes No	d d m o n y y y y Unknown
Osteopathy	Yes No	d d m o n y y y y Unknown
Chiropractic	Yes No	d d m o n y y y y Unknow
Acupuncture	Yes No	d d m o n y y y y Unknow
Other, *please specify:	Yes No	d d m o n y y y y Unknown
Other, *please specify:	Yes No	d d m o n y y y y Unknown
3. Troublesomeness of bac (tick only one)	k pain reported b	y participant during diagnostic assessment visit:
Moderately trouble	some	Very troublesome Extremely troublesome
,		' ' ' ' ' '

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Date signed:

FIS CRF version 2.1_03Aug2015 ***Draft***

Name:

Signature:

VISIT A - Eligibility / Diagnostic Assessment DIAGNOSTIC ASSESSMENT 1. Date of diagnostic assessment: d d m o n v v v y 2. Following diagnostic assessment, does the patient have the following: Check all boxes either yes or no Criteria For Assessment Yes/No No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) Yes No No sacro-iliac joint pain elicited using pain provocations test (three or more positive) Yes No No Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased low back pain on one or more of the following Yes No No No No No No No N		Fac	et Injection Stu	ıdı						
VISIT A - Eligibility / Diagnostic Assessment DIAGNOSTIC ASSESSMENT 1. Date of diagnostic assessment: d d m o n y y y y 2. Following diagnostic assessment, does the patient have the following: Check all boxes either yes or no Criteria For Assessment No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee") No sacro-iliac joint pain elicited using pain provocations test (three or more positive) Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased low back pain on one or more of the following A. Extension (more than flexion) RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: C. Extension/side flexion* RIGHT SIDE Ves		- 1		•						
VISIT A - Eligibility / Diagnostic Assessment DIAGNOSTIC ASSESSMENT 1. Date of diagnostic assessment: d d m o n y y y y y 2. Following diagnostic assessment, does the patient have the following: Check all boxes either yes or no Criteria For Assessment No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No para-spinal palpation No provide reason why: If No, provide reason why: If No for either right or left side, provide reason why: No No No No No No No No Pres No If No for either right or left side, provide reason why: LEFT SIDE Yes No No No No No Pres No Pres No	FACET INJECTION STU	UDY Par	ticipant Initials:	Site ID:	Pa	rticipant Trial ID:				
DIAGNOSTIC ASSESSMENT 1. Date of diagnostic assessment: d d m o n y y y y y 2. Following diagnostic assessment, does the patient have the following: Check all boxes either yes or no Criteria For Assessment No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee') No sacro-lilac joint pain elicted using pain provocations test (three or more positive) Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased low back pain on one or more of the following A. Extension (more than flexion) RIGHT SIDE LEFT SIDE LEFT SIDE If No for either right or left side, provide reason why: C. Extension/side flexion* RIGHT SIDE LEFT SIDE	8-8									
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1. Date of diagnostic assessment: d d m o n y y y	VISIT A - Eligibility / Diagnostic Assessment									
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Criteria For Assessment VesiNo	1. Date of diagnostic	assessn	nent:	d m o	п у у	У У				
No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee*) No sacro-iliac joint pain elicited using pain provocations test (three or more positive)	2. Following diagnos	tic asse:	ssment, does t	he patient have t	he following :					
No radicular symptoms (defined as pain radiating below the knee or objective neurological signs above the knee or objective neurological signs above the knee") No sacro-iliac joint pain elicited using pain provocations test (three or more positive) Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased low back pain on one or more of the following A. Extension (more than flexion) Yes	Check all boxes either	yes or no			_					
ating below the knee or objective neurological signs above the knee*) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) No sacro-iliac joint pain elicited using pain provocations test (three or more positive) Increased pain unilaterally, bilaterally on lumbar yes No Increased low back pain on one or more of the following A. Extension (more than flexion) RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: C. Extension/side flexion* RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: RIGHT SIDE Yes Ye	Criteria For	Assess	ment	Yes/No						
No sacro-lilac joint pain elicited using pain provocations test (three or more positive) Increased pain unilaterally, bilaterally on lumbar para-spinal palpation Increased low back pain on one or more of the following A. Extension (more than flexion) RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: C. Extension/side flexion* RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: D. Extension/rotation* RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: No No No No * Both tests representative of regular compression patterns. # Using a 'contracted' neurological examination. Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:	ating below the knee or			Yes No	<u> </u>					
Increased low back pain on one or more of the following A. Extension (more than flexion) RIGHT SIDE LEFT SIDE If No for either right or left side, provide reason why: No				Yes No	YES for th	he patient to fulfil the				
A. Extension (more than flexion) Yes		ally, bilate	erally on lumbar	Yes No	continued	d inclusion in the study				
A. Extension (more than flexion) Yes		n on <u>one</u> o	or more of the	Yes No	J					
B. Rotation	A. Extension (more tha	an flexion)	Yes No	If No, provide reas	on why :				
C. Extension/side flexion* Yes No No No RIGHT SIDE LEFT SIDE No No No * Both tests representative of regular compression patterns. # Using a 'contracted' neurological examination. Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:	B. Rotation		Yes	Yes		ht or left side, provide reason				
D. Extension/rotation* Yes No No No * Both tests representative of regular compression patterns. # Using a 'contracted' neurological examination. Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:	C. Extension/side flex	ion*	Yes	Yes		ht or left side, provide reason				
# Using a 'contracted' neurological examination. Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:	D. Extension/rotation*			Yes		ht or left side, provide reason				
# Using a 'contracted' neurological examination. Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:	* Both tests represe	ntative of	regular compres	sion patterns.	_					
Physiotherapist/investigator undertaking eligibility/diagnostic assessment: Name:										
Name :	<u> </u>				ment:					
		,		,,						
					Data signed:	DD MON WW				

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4	FACET INJECTION STUDY	Participant Init	ials: Si	ite ID:			Participant Trial ID:	
_	ISIT A - Eligibility /							
1.	Specific causes of back				<u>r no)</u>			
	Cause		Yes	es/No	No			
	Malignancy		=	_∺			*If any <u>specific</u> causes	
	Fracture		Yes	<u> </u>	No		of back pain are	
	Infection		Yes		No		identified during the diagnostic assessment	
	Possible ankylosing sp	ondylitis	Yes		No] [(ticked yes), the patient	
	Cauda equina compre	ssion	Yes		No		is <u>not eligible</u> for the	
	Radicular pain suitable	e for surgery	Yes	 _	No		study.	
_		·						
2.	Have identified <u>specif</u>		раск ра гп Not Applic	•	oortea t	o patient's	GP :	
3.	Following the diagnos		-			-	, has the patient signed	
		diagnostic assessn gnostic assessment		•			opy to investigator file	
4.	When undertaking ac	tive movements	, did the p	atient in	dicate a	ny of the f	ollowing:	
i.	ncreased pain on rising fr	om flexion	Yes [No	No	t Done, rea	son	
ii. S	Symptoms best on walkin	g	Yes [No	☐ No	ot Done, rea	son	
iii. S	ii. Symptoms best when sitting Yes No Not Done, reason							
iv.	Onset of pain paraspinal		Yes	No	☐ No	ot Done, rea	son	
рЬ	ysiotherapist/investig	ator undertaking	- aligibility	/diagnos	tic asso	ssment		
	ime :	ALUI UIIUEI LANIIS	CIIEDIIILY	, ulagilos	U33C	Jament.		
	gnature :				Date	e signed:	DD – MON-YYYY	

4	Facet Injection Study Case Report Form (CRF)										
A.A.	FACET INJECTION STUD	Particip	ant Initia	ls: Site ID:			Pai	rticipant Tr	ial ID:		
ν	VISIT A - Eligibility / Diagnostic Assessment										
	CONCOMITANT MEDICIATIONS										
	None – <u>OR</u> – comple	te									
	Drug name (trade or generic)	Dose	Unit	Frequency	Indica	ation S	tart Da Or tick u	te (dd-mm nknown	іт-уууу)		
1						_	/	[Unknown		
2						_	/	[Unknown		
3						_	/	[Unknown		
4						_	/	[Unknown		
5							/	_/[Unknown		
6							/	_/[Unknown		
7							/	_/[Unknown		
8							/	_/[Unknown		
9							/	_/[Unknown		
10						_	/	_/[Unknown		
<u>If ac</u>	lditional concomitant medi	cations are t	to be recor	ded, please use t	he 'addi	tional conce	mitant n	nedications ;	page'		
1.	Has the participant o	ampleted	studu ba	solino guartic	nnaire	durina sa	cacemo	nt vicit 2			
٠.		-	-	the reason wh				iit visit :			
	_			d questionnair							
	므	Other, ple				-					
Ph	ysiotherapist/investiga	tor under	taking eli	igibility/diagn	ostic as	sessment	:				
	me :										
Sig	nature :					Date sign	ned:	DD – MO	N-YYYY		

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FACET INJECTION STUDY	Participant Initia	ıls: Site	ID:	Participant Trial ID:					
8-8						<u> </u>			
VISIT B - BEST USUAL CARE	TREATMENT SE	SCION 1				ı	1		
		3310N I			_				
1. Date of Treatment Session: d d m o n y y y y									
Please tick the modality/technique used in each session. Where subcategories are indicated, please tick all that are performed for each session. Please refer to the BUC Manual for clarification concerning elements of modality/technique.									
Did the participant attend: Yes No, reason Or Unknown									
Modality/technique				, tick (√) NO if not stegory & sub-categ			vided as nework?		
ACCEPTANCE (compulsory)			YES		l no		YES		
GOAL SETTING (compulsory)			YES		NO		YES		
PACING (compulsory)			YES		l no		l YES		
EXERCISES (compulsory)			YES		l no] YES		
- Specific			YES		NO.		YES		
- Motor control retraining/core stabil	ity		YES		l no		YES		
- Cardiovascular			YES		l no		YES		
- Strength			YES		l no] YES		
- Stretches			YES		NO		YES		
- Other exercise, please specify:									
ADVICE			YES		l no		l YES		
- Pain terminology, mechanisms and p	pathways		YES		NO.] YES		
- Activities of Daily Living			YES		l no		YES		
- Work and ergonomics			YES		l no] YES		
- Lifestyle changes			YES		l no] YES		
- Management of flare ups & changin	g symptoms		YES		l no] YES		
- Paced home exercises			YES		l no		YES		
- Other advice, please specify:									
MANUAL THERAPY			YES		l no		YES		
- Kaltenborn			YES		l no] YES		
- McKenzie			YES		l no] YES		
- Maitland			YES		NO		YES		
- Cyriax			YES		l no		YES		
- Osteopathic techniques			YES		l no] YES		
- Mulligans			YES		NO		YES		
- (NAGS/SNAGS/MWM)			YES		NO		YES		
- Other manual therapy, please specif	fy:								
SOFT TISSUE			YES		l no		YES		
- Myo-fascial			AE2						
- Trigger point			YES						
- Soft tissue massage			YES						
- Manipulation			YES						
- Soft tissue release			YES		NO		YES		
- Other soft tissue, please specify:				<u>_</u>		<u> </u>			
CHALLENGING NEGATIVE THOUGHTS	5		YES						
MINDFULNESS			YES				YES		
Physiotherapist/investigato	or undertaking B	est Usual C	are Tr	eatment session	n :				
Name:									
Signature :				Date signed:	DD - N	ION-YYYY			

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FACET INJECTION STU		Case Report Form (CRF)						
TACET INJECTION STO	Partic	cipant Ini	tials:	Site II); 	Part	cipant Trial ID:	-, I
VISIT B - BEST USUAL C	ARE TREA	TMENT	SESSIC	ON 1				
Has the participant characters assessment visit (Visit)		medicati	on regi	mes com	pared with th	ose reported at	diagnostic	
Yes—please complet	e the table	below			No—move to	question 2		
Drug name (trade or generic)	Dose	Unit	Freq	uency	Indication	Start Date (dd- Or tick unknow	mmm-yyyy) 'n	
							Unl	nown
							Unl	nown
							Unl	nown
						//_	Unl	known
							Unl	nown
							Unl	nown
Please indicate in the health care profession		•	ent sin	ce the di	agnostic asses			_
Treatment type		Yes	No	known	record the nu	ilibei oi visits be	iow, or tick un-	
Physiotherapy				Numbei	of visits:		Unknown	
Osteopathy				Numbei	of visits		Unknown	
Chiropractic				Numbei	of visits:		Unknown	\neg
Acupuncture				Number	of visits:		Unknown	\neg
Other, specify				Numbei	of visits:		Unknown	\neg
Other, specify				Numbei	of visits:		Unknown	
Action Needed (tick all tha	t apply)							
☐ None, patient deeme	d treatme	nt conclu	ded, n	otify WC1	·u			\neg
☐ None, patient to con	tinue							
☐ Discuss treatment or	tions with	colleague	es					
☐ Review management	to date							
☐ Post Query on the FI	S Discussio	n Forum						
Physiotherapist/investig	gator und	ertaking	Best l	Jsual Ca	re Treatmen	t session :		
Name :								

DD - MON-YYYY

Participant Initials: Site ID: Participant Trial ID: VISIT B - BEST USUAL CARE TREATMENT SESSION 2 1. Date of Treatment Session: d d m o n y y y y y y Please tick the modality/technique used in each session. Where subcategories are indicated, please tick all that are performed for each session. Please refer to the BUC Manual for clarification concerning elements of modality/technique. Did the participant attend: Yes No, reason	
VISIT B - BEST USUAL CARE TREATMENT SESSION 2 1. Date of Treatment Session: d d m o n y y y y y Please tick the modality/technique used in each session. Where subcategories are indicated, please tick all that are pe formed for each session. Please refer to the BUC Manual for clarification concerning elements of modality/technique . Did the participant attend: Yes No, reason	: Participant Trial ID:
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formed for each session. Please refer to the BUC Manual for clarification concerning elements of modality/technique. Did the participant attend: Yes No, reason	л у у у
Did the participant attend: Yes No, reason	categories are indicated, please tick all that are per-
Modality/technique Tick (✓) YES if used, tick (✓) NO if not used for each leading category & sub-category Provided an homework ACCEPTANCE (compulsory) YES NO YES GOAL SETTING (compulsory) YES NO YES PACING (compulsory) YES NO YES EXERCISES (compulsory) YES NO YES - Specific YES NO YES - Motor control retraining/core stability YES NO YES - Cardiovascular YES NO YES - Strength YES NO YES - Stretches YES NO YES - Other exercise, please specify: NO YES ADVICE YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	tion concerning elements of modality/technique.
Modality/technique leading category & sub-category homework ACCEPTANCE (compulsory) YES NO YES GOAL SETTING (compulsory) YES NO YES PACING (compulsory) YES NO YES EXERCISES (compulsory) YES NO YES - Specific YES NO YES - Motor control retraining/core stability YES NO YES - Cardiovascular YES NO YES - Strength YES NO YES - Stretches YES NO YES - Other exercise, please specify: YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
ACCEPTANCE (compulsory)	
GOAL SETTING (compulsory) YES NO YES PACING (compulsory) YES NO YES EXERCISES (compulsory) YES NO YES - Specific YES NO YES - Motor control retraining/core stability YES NO YES - Cardiovascular YES NO YES - Strength YES NO YES - Stretches YES NO YES - Other exercise, please specify: YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
PACING (compulsory) YES NO YES EXERCISES (compulsory) YES NO YES - Specific YES NO YES - Motor control retraining/core stability YES NO YES - Cardiovascular YES NO YES - Strength YES NO YES - Stretches YES NO YES - Other exercise, please specify: YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Work and ergonomics YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
EXERCISES (compulsory) YES NO YES - Specific YES NO YES - Motor control retraining/core stability YES NO YES - Cardiovascular YES NO YES - Strength YES NO YES - Stretches YES NO YES - Other exercise, please specify: YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Lifestyle changes YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
- Specific	
- Motor control retraining/core stability	
- Cardiovascular	
- Strength	
- Stretches	
Other exercise, please specify:	
ADVICE YES NO YES - Pain terminology, mechanisms and pathways YES NO YES - Activities of Daily Living YES NO YES - Work and ergonomics YES NO YES - Lifestyle changes YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
- Pain terminology, mechanisms and pathways	ES D NO D YES
- Activities of Daily Living	
- Work and ergonomics YES NO YES - Lifestyle changes YES NO YES - Management of flare ups & changing symptoms YES NO YES - Paced home exercises YES NO YES	
- Lifestyle changes	
- Management of flare ups & changing symptoms	
- Paced home exercises PYES NO YES	
- Other advice, please specify:	ES NO YES
MANUAL THERAPY	ES NO YES
- Kaltenborn	ES NO YES
- McKenzie	ES NO YES
- Martland YES NO YES	ES NO YES
- Cyriax	ES NO YES
- Osteopathic techniques	ES NO YES
- Mulligans PYES NO YES	ES NO YES
- (NAGS/SNAGS/MWM)	ES NO YES
- Other manual therapy, please specify:	
SOFT TISSUE PES NO YES	ES NO YES
·	ES NO YES
· · · · · · · · · · · · · · · · · · ·	
	'ES NO YES
- Other soft tissue, please specify:	
Physiotherapist/investigator undertaking Best Usual Care Treatment session : Name :	e i reatment session :

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Signature :

	Facet Injection Study Case Report Form (CRF)												
FACET INJECTION STU		ipant Ini	-	Site II	۸٠		<u> </u> Participan	t Trial ID:	\dashv				
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VISIT B - BEST USUAL C	ARE TREA	TMENT	SESSIO	N 2									
Has the participant characteristic treatment session visit Yes—please complet	7		on regir		pared with to	·	rted at the pr	evious					
Drug name (trade or generic)	Dose	Unit	Frequ	ency	Indication	on Start Date (dd-mmm-yyyy) Or tick unknown							
								Unkno	wn				
			1					Unkno	wп				
						/_		Unkno	wn				
								Unkn					
						/_		Unkno	wn				
						/_	/	Unkno	wn				
Please indicate in the table below if the participant has undergone any other (non-trial specified) registered health care professional delivered treatment since the previous treatment session Tick one: If Yes , record the number of visits below, or tick unknown If Yes No Known If Yes No If Yes No If Yes No If Yes If Yes													
Physiotherapy				Numbe	er of visits:			Unknown	┪				
Osteopathy				Numbe	er of visits			Unknown	┪				
Chiropractic				Numbe	er of visits:			Unknown	٦				
Acupuncture				Numbe	er of visits:			Unknown					
Other, specify				Numbe	er of visits:			Unknown					
Other, specify				Numbe	er of visits:			Unknown					
Best Usual Care Session Re	view		Action	Needed	(tick all that	apply)							
□ Unknown, participant d	lid not atte	nd	□ No	ne, patie	ent deemed t	treatment	concluded , n	otify WCTU					
□ Better			□ No	ne, pati	ent to contin	iue							
☐ Worse			□ Di	scuss tre	atment opti	ons with co	lleagues						
☐ The Same			□ Re	view ma	nagement to	o date							
			l		on the FIS E		Forum						
Physiotherapist/investig													
r irysiotherapist/irivestig	ator unde	ertaking	Best U	sual Ca	re Treatmei	nt session	•						
Name :	ator unde	ertaking	Best U	sual Car	re Treatmei	nt session	:						

	Facet Injection Case Report Fo	-									
FACET INJECTION STUDY	Participant Initia	ıls: Site	ID:		Particir	I Irticipant Trial ID:					
124		 		1 1 1	Particip	Jant Iriai ib:					
VISIT B - BEST USUAL CARE	TREATMENT SE	SSION 3									
1. Date of Treatment Session	: d d	m o	n	у у у	У						
Please tick the modality/technique	used in each sessi	on. Where s	ubcateg	gories are indicate	d, please ticl	all that are per					
formed for each session. Please ref	ier to the BUC Mar	nual for clari	fication	concerning eleme	nts of moda	ity/technique .					
Did the participant attend:	Yes No,	reason		Or	Unkn						
Modality/technique				, tick (√) NO if not u stegory & sub-catego		Provided as homework?					
ACCEPTANCE			YES		NO	☐ YES					
GOAL SETTING			YES		NO	☐ YES					
PACING			YES		NO	☐ YES					
EXERCISES			YES		NO	☐ YES					
- Specific			YES		NO	☐ YES					
- Motor control retraining/core stability	<i>'</i>		YES			☐ YES					
- Cardiovascular			YES			☐ YES					
- Strength			YES			☐ YES					
- Stretches			YES		NO	☐ YES					
- Other exercise, please specify:											
ADVICE			YES			☐ YES					
- Pain terminology, mechanisms and pa	thways		YES			☐ YES					
- Activities of Daily Living			YES		NO	☐ YES					
- Work and ergonomics			YES			☐ YES					
- Lifestyle changes			YES			☐ YES					
- Management of flare ups & changing	symptoms		YES		NO	☐ YES					
- Paced home exercises			YES		NO	☐ YES					
- Other advice, please specify:											
MANUAL THERAPY			YES			☐ YES					
- Kaltenborn			YES			□ YES					
- McKenzie			YES			☐ YES					
- Maitland			YES			☐ YES					
- Cyriax			YES			□ YES					
- Osteopathic techniques			YES			☐ YES					
- Mulligans			YES		NO	☐ YES					
- (NAGS/SNAGS/MWM)			YES		NO	☐ YES					
- Other manual therapy, please specify	1		VEC		No						
SOFT TISSUE			YES			☐ YES					
- Myo-fascial			YES			☐ YES					
- Trigger point - Soft tissue massage			YES			☐ YES					
- Manipulation			YES			☐ YES					
- Soft tissue release			YES			☐ YES					
- Other soft tissue, please specify:						 					
CHALLENGING NEGATIVE THOUGHTS			YES		NO	☐ YES					
MINDFULNESS			YES			□ YES					
Physiotherapist/investigator	undertaking Br										
Name :	under taking be	est osual t	are III	cacinent sessio							
Signature :				Date signed:	DD – MON-	VYVV					

Facet Injection Study																
سـمم		_	orm (CR	F)												
TACET INJECTION STUD	Y Partic	ipant Ini	tials:	Site II) :					Participant Trial ID:						
8-9																
VISIT B - BEST USUAL CA	RE TREA	TMENT	SESSION	3												
treatment session visit	Has the participant changed any medication regimes compared with those reported at the previous treatment session visit? Yes—please complete the table below No—move to question 2 Drug name Dose Unit Frequency Indication Start Date (dd-mmm-yyyy)															
Drug name	Dose	Unit	Frequer	ıcv	Indi	cation	St	art Da	ate	(dd-	mmm	- УУУУ	<i>ı</i>)			
(trade or generic)	D032	Ome	Treque	,		cucion	0	tick	uni	know	n		•			
													Unknown			
													Unknown			
													Unknown			
								/		_/_			Unknown			
								/_		_/_			Unknown			
													Unknown			
2. Please indicate in the table below if the participant has undergone any other (non-trial specified) registered health care professional delivered treatment since the previous treatment session																
Treatment type		Tick on Yes	ie: <i>No</i>	If Yes		ord th	e nun	nber	of v	visits	below	, or 1	tick un-			
Physiotherapy				Numl	ber of	visits:						Ur	nknown			
Osteopathy				Numl	ber of	visits					Ī	Ur	nknown			
Chiropractic				Numl	ber of	visits:						Ur	ıknown			
Acupuncture				Numl	ber of	visits:						Ur	nknown			
Other, specify				Numl	ber of	visits:						Ur	nknown			
Other, specify				Numl	ber of	f visits:						Ur	nknown			
Best Usual Care Session Rev	iew		Action N	eeded	(tick	all tha	t app	ly)								
□ Unknown, participant di	d not atte	nd	□ None	e, patie	ent de	eemed	treat	ment	со	nclud	ed, no	otify \	wctu			
□ Better			□ Non	e, pati	ent to	o contin	nue									
□ Worse			☐ Disc	uss tre	atme	nt opti	ions v	vith co	olle	eague	s					
☐ The Same			□ Revi	ew ma	nage	ment t	o dat	e								
			☐ Post	Quen	on t	he FIS (Discu:	ssion	Foi	rum						
Physiotherapist/investiga	ator unde	ertaking	Best Usu	ial Ca	re Tr	eatme	nt se	ssion	1:							
Name:																

 $\mathsf{DD} - \mathsf{MON}\text{-}\mathsf{YYYY}$

	Facet Injection Case Report Fo						
FACET INJECTION STUDY	Participant Initia	ıls: Site	ID:		Pa	rticipant Tria	al ID:
78-87						recipant in	
VISIT B - BEST USUAL CARE	TDEATMENT SE	SSION 4					
_		331011 4			_		
1. Date of Treatment Sessio	n: d d	m o	n	у у у	У		
Please tick the modality/techniqu					-		
formed for each session. Please r	efer to the BUC Mai	nual for clari	fication	concerning eleme	ents of n	nodality/tech	nique .
Did the participant attend:	Yes No,	reason		o	r 🔲 L	Jnknown	
		Tick (v/) VE	S if used	, tick (√) NO if not	used for a	each Pro	ovided as
Modality/technique				ategory & sub-categ			mework?
ACCEPTANCE			YES		-		
GOAL SETTING			YES				
PACING			YES				□ YES
EXERCISES			YES				YES
- Specific			YES				YES
- Motor control retraining/core stabil	ity		YES				O YES
- Cardiovascular			YES				□ YES
- Strength			YES		NO		YES
- Stretches			YES		NO.		
- Other exercise, please specify:							
ADVICE			YES		NO		☐ YES
- Pain terminology, mechanisms and	pathways		YES		NO		YES
- Activities of Daily Living			YES		NO [YES
- Work and ergonomics			YES		l NO		YES
- Lifestyle changes			YES		NO [☐ YES
- Management of flare ups & changin	g symptoms		YES		NO		YES
- Paced home exercises			YES		NO		□ YES
- Other advice, please specify:							
MANUAL THERAPY			YES		NO		YES
- Kaltenborn			YES		NO.		YES
- McKenzie			YES		NO [YES
- Maitland			YES] NO		☐ YES
- Cyriax			YES		NO.		YES
- Osteopathic techniques			YES] NO		☐ YES
- Mulligans			YES		NO		YES
- (NAGS/SNAGS/MWM)			YES		NO		YES
- Other manual therapy, please specif	fy:						
SOFT TISSUE			YES				□ YES
- Myo-fascial			YES				YES
- Trigger point			YES				
- Soft tissue massage			YES				YES
- Manipulation			YES				YES
- Soft tissue release			YES		NO		□ YES
- Other soft tissue, please specify:			VF-		1 8:		
CHALLENGING NEGATIVE THOUGHTS	•		YES				
MINDFULNESS			YE5				□ YES
Physiotherapist/investigato	r undertaking B	est Usual C	are Tr	eatment session	n:		
Name :				Data si di	DD -	ACM MAAA	
Signature:				Date signed:	א – טט	MON-YYYY	

	Facet Injection Study Case Report Form (CRF)													
FACET INJECTION S		cipant In		Site II):				Participant Trial ID:					
245	1.0.0				·									
VISIT B - BEST USUAI	L CARE TREA	TMENT	SESSION	14										
Has the participant of treatment session v Yes—please comp	isit ?		on regim	1		with t			rte	d at 1	the pr	eviou	s	
Drug name (trade or generic)	Dose	Unit	Freque	ncy	Indic	ation	Sta Or	ırt Da tick u	ite	(dd-i)			
													Unknown	
				/_									Unknown	
													Unknown	
								/		_/_			Unknown	
							/			Unknown				
													Unknown	
Please indicate in the table below if the participant has undergone any other (non-trial specified) registered health care professional delivered treatment since the previous treatment session														
Treatment ty	pe	Tick or Yes	ne: <i>No</i>	If Yes		ord the	e num	ber o	of v	risits	below	, or t	ick un-	
Physiotherapy				Num	ber of	visits:						Un	known	
Osteopathy				Num	ber of	visits						Un	known	
Chiropractic				Num	ber of	visits:						Un	known	
Acupuncture				Num	ber of	visits:						Un	known	
Other, specify				Num	ber of	vis i ts:						Un	known	
Other, specify				Num	ber of	visits:						Un	known	
Best Usual Care Session	Review		Action f	leeded	(tick a	all that	apply	y)						
□ Unknown, participar	nt did not atte	end	⊔ Nor	e, pati	ent de	emed t	treatn	nent	coi	nclud	ed			
☐ Better			□ No	ne, pati	ent to	contin	ue							
□ Worse			□ Dis	cuss tre	atmer	nt optic	ons wi	ith co	lle	ague	s			
☐ The Same			☐ Rev	iew ma	anagen	nent to	o date	!						
			☐ Pos	t Quen	y on th	e FIS D	Discus	sion I	For	um				
Physiotherapist/inves	stigator und	ertaking	Best Us	ual Ca	re Tre	atmer	nt ses	sion	:					
Name :														
Signature :						Date	signed	ı:	DI) – M	ON-YY	ΥY		

	Facet Injection Case Report Fo							
FACET INJECTION STUDY	Participant Initia	ıls: Site	ID:		Participa	int Trial ID:		
					7 47 27 27 27			
VISIT B - BEST USUAL CARE	TREATMENT SE	SSION 5						
1. Date of Treatment Sessio	n: d d	m o	n	V V V	T v			
Please tick the modality/techniqu			ubcateg	ories are indicate	d, please tick	all that are per-		
formed for each session. Please re	efer to the BUC Ma	nual for clari	fication	concerning eleme	nts of modalit	y/technique		
Did the participant attend:	Yes No,	reason	**********	Or	Unkno	wn		
Modality/technique				, tick (✔) NO if not u tegory & sub-categ		Provided as homework?		
ACCEPTANCE			YES		NO	☐ YES		
GOAL SETTING			YES		NO	☐ YES		
PACING			YES		NO	☐ YES		
EXERCISES			YES		NO	☐ YES		
- Specific			YES		NO	☐ YES		
- Motor control retraining/core stabili	ity		YES			☐ YES		
- Cardiovascular			YES		NO	☐ YES		
- Strength			YES		NO	☐ YES		
- Stretches			YES		NO	☐ YES		
- Other exercise, please specify:								
ADVICE			YES			☐ YES		
- Pain terminology, mechanisms and p	pathways		YES			☐ YES		
- Activities of Daily Living		YES			☐ YES			
- Work and ergonomics			YES			☐ YES		
- Lifestyle changes			YES			☐ YES		
- Management of flare ups & changin	g symptoms		YES			☐ YES		
- Paced home exercises			YES		NO	☐ YES		
- Other advice, please specify:								
MANUAL THERAPY			YES			☐ YES		
- Kaltenborn			YES			☐ YES		
- McKenzie			YES			☐ YES		
- Maitland			YES			☐ YES		
- Cyriax			YES			□ YES		
- Osteopathic techniques			YES			□ YES		
- Mulligans			YES			☐ YES		
- (NAGS/SNAGS/MWM)			A F 2		NO	☐ YES		
- Other manual therapy, please specif	ÿ:		WEE		No	☐ YES		
NAVO foscial			YES			☐ YES		
- Myo-fascial			YES			☐ YES		
- Trigger point - Soft tissue massage			YES			☐ YES		
- Manipulation			YES			☐ YES		
- Soft tissue release			YES			□ YES		
- Other soft tissue, please specify:								
CHALLENGING NEGATIVE THOUGHTS	;		YES		NO	☐ YES		
MINDFULNESS			YES			☐ YES		
Physiotherapist/investigato	r undertaking B	est Usual (are Tr	eatment sessio	n:			
Name :	. andertaking Di	est osual t	are III					
Signature :				Date signed:	DD - MON-Y	YYY		

		Facet Injection Study Case Report Form (CRF)												
FACET INJECTION STUD		<u>'</u>							Participant Trial ID:					
TACET INJECTION STOL	Partic	ipant Ini	tials:	Site II):			ī	Pai	rticip	ant T	'rial I	D:	
	l													
VISIT B - BEST USUAL CA	ARE TREA	TMENT	SESSION	15										
Has the participant cha treatment session visit		medicati	on regim	es com	pare	d with	those	e repo	rted a	t the	prev	rious		
Yes—please complete the table below No—move to question 2 Drug name (trade or generic) Dose Unit Frequency Indication Start Date (dd-mmm-yyyy) Or tick unknown														
Drug name (trade or generic)	Dose	Unit	Freque	ncy	Indi	cation	St O	tart Da r tick (ite (di unkno	d-mm wn	ım-y	ууу)		
													Jnknowr	
					//_							l	Jnknowr	
												Ţι	Jnknowr	
												U	Jnknowr	
]_	_/_	/_			l	Jnknowr	
							T_	/_			_ [L	Jnknowr	
2. Please indicate in the table below if the participant has undergone any other (non-trial specified) registered health care professional delivered treatment since the previous treatment session														
Treatment type		Tick o	ne: <i>No</i>	If Yes		ord th	ie nur	nber o	f visit	s bel	ow,	or tic	:k un-	
Physiotherapy				Num	ber of	visits	:					Unk	nown	
Osteopathy				Num	ber of	visits						Unkı	nown	
Chiropractic				Num	ber of	visits	:					Unki	nown	
Acupuncture				Num	ber of	visits	:					Unki	nowп	
Other, specify				Num	ber of	visits	:					Unki	nown	
Other, specify				Num	ber of	visits	:					Unkı	nown	
Best Usual Care Session Rev	/iew		Action N	leeded	l (tick	all tha	it app	ly)						
□ Unknown, participant di	id not atte	nd	□ Non	e, pati	ent de	eemed	l treat	ment	conclu	ıded,	noti	fy W	сти	
☐ Better			□ Nor	ne, pati	ient to	conti	nue							
□ Worse			☐ Disc	cuss tre	eatme	nt opt	ions v	with co	lleagu	ıes				
☐ The Same			☐ Rev	iew m	anage	ment :	to dat	te						
			☐ Pos	t Quer	y on t	he FIS	Discu	ssion l	Forum	,				
Physiotherapist/investig	ator unde	ertaking												
N														

DD - MON-YYYY

60.4	Facet Injection Case Report Fo	•				
FACET INJECTION STUDY	Participant Initia	ıls: Site	ID:		 Dartic	ipant Trial ID:
100	Participant initia	iis. Site	D;		raitic	ipanii iliai ib:
VISIT B - BEST USUAL CARE	TREATMENT SE	SSION 6				
Date of Treatment Sessio		33/0/10	$\overline{}$		$\overline{}$	
	G G	m o	n	у у у	У	
Please tick the modality/techniqu						
formed for each session. Please of Did the participant attend:		reason				nown
Modality/technique				, tick (√) NO if not u stegory & sub-catego		Provided as homework?
ACCEPTANCE			YES		NO	□ YES
GOAL SETTING			YES		NO	☐ YES
PACING			YES			□ YES
EXERCISES			YES			☐ YES
- Specific			YES			☐ YES
- Motor control retraining/core stabili	tv		YES		NO	☐ YES
- Cardiovascular			YES		NO	☐ YES
- Strength			YES		NO	☐ YES
- Stretches			YES		NO	☐ YES
- Other exercise, please specify:						
ADVICE			YES		NO	☐ YES
- Pain terminology, mechanisms and p	pathways		YES		NO	☐ YES
- Activities of Daily Living			YES		NO	☐ YES
- Work and ergonomics			YES			☐ YES
- Lifestyle changes			YES		NO	☐ YES
- Management of flare ups & changing	g symptoms		YES		NO	☐ YES
- Paced home exercises			YES		NO	☐ YES
- Other advice, please specify:						
MANUAL THERAPY			YES		NO	☐ YES
- Kaltenborn			YES		NO	☐ YES
- McKenzie			YES		NO	☐ YES
- Maitland			YES		NO	☐ YES
- Cyriax			YES		NO	☐ YES
- Osteopathic techniques			YES		NO	☐ YES
- Mulligans			YES		NO	☐ YES
- (NAGS/SNAGS/MWM)			YES		NO	☐ YES
- Other manual therapy, please specif	y:					
SOFT TISSUE	,		YES		NO	☐ YES
- Myo-fascial			YES		NO	☐ YES
- Trigger point			YES		NO	☐ YES
- Soft tissue massage			YES		NO	☐ YES
- Manipulation			YES		NO	☐ YES
- Soft tissue release			YES		NO	☐ YES
- Other soft tissue, please specify:						
CHALLENGING NEGATIVE THOUGHTS			YES		NO	☐ YES
MINDFULNESS			YES		NO	☐ YES
Physiotherapist/investigato	r undertaking B	est Usual (are Tr	eatment sessio	n:	
Name :						
Signature :				Date signed:	DD-MON	I-YYYY

م مد		Facet Injection Study Case Report Form (CRF)											
FACET INJECTION	STUDY Pa	rticipant In	itials:	Site ID:			Particip	ant Tria	il ID:				
VISIT B - BEST USUA	L CARE TR	REATMENT	SESSION	6									
Has the participant treatment session v Yes—please comp	risit ?		ion regim	·		nose repo		previou	ns				
Drug name (trade or generic)	Dose	Unit	Freque		cation		ate (dd-mm unknown	ım-yyyy	<i>i</i>)				
			+			1			Unknown				
			+			 		_	Unknown				
	_		+			 			Unknown				
			+						Unknown				
			1						Unknown				
									Unknown				
2. Please indicate in the health care professi		-	-	-			-	cified) ı	registered				
Treatment ty	pe	Tick of Yes	ne: <i>No</i>	If Yes , re known	cord the	number	of visits bel	ow, or i	tick un-				
Physiotherapy				Number o	f visits:			Ur	nknown				
Osteopathy				Number o	f visits			Ur	nknown				
Chiropractic				Number o	f visits:			Ur	nknown				
Acupuncture				Number o	f visits:			Ur	nknown				
Other, specify				Number o	f visits:			Ur	nknown				
Other, specify				Number o	f visits:		[Ur	nknown				
Best Usual Care Session	Review		Action N	leeded (tick	all that	apply)							
□ Unknown, participa	nt did not a	attend	□ Non	e, patient d	eemed ti	reatment	concluded,	notify \	WCTU				
□ Better			□ Nor	ie, patient t	o continu	1e							
□ Worse	☐ Discuss treatment options with colleagues												
□ The Same			□ Rev	iew manage	ement to	date							
			□ Pos	t Query on t	he FIS D	iscussion	Forum						
Physiotherapist/inve	stigator u	ndertaking	Best Usi	ual Care Tr	eatmen	t sessior	1:						
Name :													
Signature :					Date s	igned:	DD - MON-	-YYYY					

	Facet Injection Stud Case Report Form (C			
FACET INJECTION ST	Participant Initials:	Site ID:	Pa	rtîcipant Trial ID:
VISIT C - INJECTION				
Not applicable	e, participant randomised to	Best Usual Care only	′	
1. Date of injection:	d d m o n	у у у	У	
2. Is the participant sti	l considered suitable for t	he study facet join	t injection pro	cedure ?
Yes - ensure s	tandard NHS/Trust consent s	igned by participant	for injection pro	ocedure
No*, specify th	ne reason(s) why			
*If No. is the particina	nt still willing to continue wi	th the RUC treatmen	rt sessions ?	
	schedule BUC treatment ses		30330113 .	
No - complete	e withdrawal CRF page and e	nd of study treatmer	nt CRF page	
3. Was the injection po	stponed or rescheduled by t	ne investigator or ot	her trial person	nel?
Yes *	No			
* If yes, please spec	fy the reason why below:			
Equipment Failu	ire			
Participant unde	erlying local infection			
Other, please sp	ecify reason;			
Investigator responsible	for injection			
Name :	<u> </u>			
Signature :		1	Date signed:	DD - MON-YYYY

				cet Injection		-					Π				
	ACET INJE	CTION ST		rticipant Ini		Site II) :			Pa	 irticîpant	Tria	l ID:		1
0-0															
wer	C INUE	CTION				'					_				,
	C - INJE														╛
1. Pa	in outco	mes repo	orted by	participan	t imme	diately	befo	re in	jection (within (60 minu	tes):			
	n a 0 to 10 ection?	-	-	, 10 = wors f the report			ne par	rticipa	ant's aver	age pair	reporte	d imr	nedia	ately	pre
	0	1	2 3	4	5	6		7	8	9	10				
												_			
2.	Start tim	e of inje	tion:]: [24	1 hour	forma	rt .						
3.	End time	of inject	ion:]: [24	1 hour	forma	at						
4.	Confirma	ition of i	ijectate	Dose	В	atch no	·:	Ex	piry date:						
	preparat											_		_	
	Levobup	vacaine 5	mg/ml		L	d d	m	n	У	У	У	У			
	Triamcin	olone 10ı	mg/ml	C	mi				d d	m	o n	У	У	У	У
				•											
5.	Total No	o. of face	t joints in	jected:		(numbe	er 1 to	6 inc	:lusive)						
Joints	Injected		1	ide injected	and vol	ume			IT side in inistered	•	nd volun	ne			
L3/L4		Yes		Yes, Volume	≘: ┌┌.	m		┢	Yes, Vo	lume: [$\neg \vdash$]ml			1
		No		No				ᆫ] No	L		J			
L4/L5		Yes		Yes, Volum	≘:	m m	1	Г	Yes, Vo	lume:	$\neg \vdash$]ml			
		No		No] No	•		_			
L5/S1		Yes		Yes, Volume	e:	m		Г	Yes, Vo	lume: [$\neg \vdash$	ml			1
		No		No	Ш	Ш			j No	L		_			
lesses			aible for	iminotio-											_
		respon	sible for	injection											
Nan	ne :		-						Dato	ianad:	DD.	MON	LVV	VV	\dashv

	٠		njection Stud						
TACET INJECTION STUDY		Particip	pant Initials:	Site ID:		Parti	Participant Trial ID:		
vis	IT C - INJECTION	•							
1.	1. Resistance to injection: Yes* No								
	* If Yes, please tick the reasons for resistance:								
	Abutment of the needle bevel to a surface								
	Fili	ng of the intra	-articular space	è					
	Oti	ner, Specify rea	ason;						
2.	2. Pain outcomes reported by participant immediately after injection (within 60 minutes) On a 0 to 10 scale (0 = no pain, 10 = worst pain) what is the participant's average pain reported pain immediately after injection? (circle only one of the reported number)								
	0 1	2 3	4 5	6 7	8	9	10		
3.	Was the injection manual? Yes No Sp	ecify reason w	hy;		vith the study		······		
4.	4. Cumulative exposure time: 24 hour format								
5.	. Total radiation exposure from facet joint injection procedure: mSv								
Inve	estigator responsible	for injection:							
Nan	ne :								
Sign	nature :				Date signe	d: DD-	- MON-YYYY		

	Facet Injection Study						
FACET INJECTION STUDY	Case Report Form (CRF) Participant Initials: Site ID:	D-	rticipant Trial ID:				
48.	Participant Illitials: Site ID:						
VISIT C - INJECTION							
Injection site monitoring – immediately Pre injection (within 5-10 minutes before injection)							
Not Done, specify reason why:							
1. Time observed: 24 hour format							
2. Finding—Tick all that a	normal						
	bleeding						
	haematoma						
	redness						
	infection						
	other, specify:						
Injection site monitoring -	- Post injection (within 60 minutes po	st injection)					
Not Done, specify rea	son why:		***************************************				
3. Time observed:	: 24 hour format						
4. Finding—Tick all that	t apply: normal						
	bleeding						
	haematoma						
	redness						
	infection						
	other, specify:						
5. Was the participant provided with post injection advice in accordance with current hospital procedures ?							
Yes	No						
Investigator responsible for injection:							
Name:							
Signature :		Date signed:	DD – MON-YYYY				

	Facet Injection Stud						
	Case Report Form (CRF)					
FACET INJECTION STUDY	Participant Initials:	Site ID:		Participant Trial ID:			
END OF ALLOCATED	TREATMENT—S	UMMARY					
		_	_				
 Did the participant co 		cated treatm	ent?				
Yes	No *						
	_						
2. Date and time allocat	ed treatments ended	:					
d d m o	n v v	, I ,		м м			
d d iii o	у у	УУ		IN IN			
* If No, specify the primary r	eason for participant d	iscontinuation	/withdrawal:				
		•					
3. At the end of the allo		at action is su	agastad for the	nauticinant 3			
5. At the end of the and	ocated treatment, wh	at action is su	iggested for the	participant r			
Refer back to pa	rticipant's GP for additio	onal treatment(s)				
No further treate	ment advised						
Other, please specify:							
Instruction to site: Please							
tails have changed, please complete a new Participant Contact Details Form to ensure postal follow up ques-							
tionnaires at 3, 6 and 12m are mailed out from WCTU to participant correct address. Please ensure the study enrolment log is updated.							
eniforment log is apaated.							
INIVESTIGATOR STATEMENT							
INVESTIGATOR STATEMENT							
I certify that I have reviewed this case report form for this participant and verify to the best of my knowledge							
that the information contained herein is true, accurate and complete.							
Name:							
61			Bass stands	DD MONIMON			

输	Facet Injection Study Case Report Form (CRF)							
FACET INJECTION STUDY	Participant Initials:	Site ID:		Part	icipant	Trial I	D:	

				<u> </u>			
Additional Information Form							
Please use this page to provide any additional information, comments or details relating to the information or study procedures on the above referenced participant:							
inionnation c	n stady	procedures on the ab	ove releieliceu par	пстрапт.			
Page No:	Visit	Question Ref	Comments				
General Com	ments:						
Physiotherapist/investigator signature							
Name:							
Signature :				Date signed:	DD – MON-YYYY		